Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		NVS4677AGC		B. WING		1	, 1/2010
DESERT PREEZE CARE SERVICES INC. 1872 HAS			1872 HASIE	RESS, CITY, STA B COURT S, NV 89156	TE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
Y 000	Initial Comments			Y 000			
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.						
	a result of an annual conducted on your fact 10/11/10. This State	•	·				
	persons and/or perso Category II residents. the survey was three. reviewed and three el	Is for elderly and disablens with chronic illnesse. The census at the time. Three resident files we	es, e of				
	The following deficien	ncies were identified:					
Y 072 SS=E	449.196(3) Qualificati Training	ions of Caregiver-Med		Y 072			
	facility in the administ including, without limi medication or dietary must: (a) Receive, in addition pursuant to NRS 449 training in the manage caregiver must receive	ts a resident of a resident of any medication of any medication tation, an over-the-coursupplement, the caregion to the training require.037, at least 3 hours of medication. The the training at least enterties of medication and the second s	nn, nter iver ed f he every		Ethic statement of deficiencies		

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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		NVS4677AGC		B. WING		C 10/11	/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
DESERT E	BREEZE CARE SERVICE	S, INC	1872 HASIE LAS VEGAS	3 COURT 5, NV 89156			
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Y 072	Continued From page	e 1		Y 072			
	satisfactory evidence training and his attend	dance at the training; a ears, pass an examinat ement of medication	nd				
	This Regulation is not met as evidenced by: Based on record review on 10/1/10, the facility failed to ensure that 1 of 3 caregivers had completed the required three hour medication management refresher training every three years (Employee #1). Severity: 2 Scope: 2						
Y 103 SS=F	449.200(1)(d) Person Tuberculosis	nel File - NAC 441A /		Y 103			
	a separate personnel member of the staff o include:	ates required pursuant	ach				
		ot met as evidenced by: ew from 10/1/10 throug ailed to ensure 3 of 3					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	NVS4677AGC			B. WING		10/1	7/2010
NAME OF PE	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		0.10
DESERT E	BREEZE CARE SERVIC	ES, INC	1872 HASIE LAS VEGAS	3 COURT 5, NV 89156			
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Y 103	Continued From pag	je 2		Y 103			
	employees complied with NAC 441A.375, 3 of 3 employees did not have pre-employment physicals (Employee #1, #2, and #3) and 2 of 3 employees did not have annual TB signs and symptoms reviews (Employees #1 and #2).						
	This was a repeat de State Licensure surv	eficiency from the 10/21/ ey.	09				
	Severity: 2 Scope: 3						
Y 105 SS=F	449.200(1)(f) Persor	nnel File - Background C	heck	Y 105			
	a separate personne member of the staff include:	ise provided in subsection If the must be kept for eaction of a facility and must Diance with NRS 449.17	ach				
	Based on record rev failed to ensure 3 of background check re to 449.188 (Employe	equirements of NRS 449 ee #1 missing a copy of e, Employee #2 and #3	ity				
	This was a repeat de State Licensure surv	eficiency from the 10/21/ vey.	09				
	Severity: 2 Scope:	3					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	NVS4677AGC			B. WING		10/1	; 1/2010
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	L RESS, CITY, STA	TE, ZIP CODE	10/1	1/2010
DESERT E	BREEZE CARE SERVICE	S, INC	1872 HASIE LAS VEGAS	3 COURT S, NV 89156			
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Y 178 SS=D	449.209(5) Health and Int/Ext	d Sanitation-Maintain		Y 178			
	ensure that the premis	of a residential facility sl ses are clean and that andscaping of the facili	the				
	Based on observation failed to ensure the primaintained (Master befood particles and oth the hallway) and the fipremises of the facility hazards (Vinyl blinds loose floor tiles in the Severity: 2 Scope:	1	well S, els in the m				
Y 252 SS=F	449.217(3) Storage of Packaging	f Food-Adequate storaç	ge;	Y 252			
	food and equipment u	must be available for all used for cooking and sto ored must be appropriat	oring				
		ot met as evidenced by: n on 10/1/10, the facility					

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Y 252	Continued From page	e 4		Y 252			
	for dry and canned fo were stacked on the I the wall near the refri	cient storage was availa and (Cans and boxes of kitchen floor and up aga gerator due to overcrow . Boxes of food suscep	food ainst vding				
	ocverty. 2 ocope.	. •					
Y 435 SS=C	449.229(4) Fire Extin	guisher; Inspection		Y 435			
	recharged and tagged	uishers must be inspect d at least once each ye the State Fire Marshall ions.	ar by				
	Severity: 1 Scope: 3	3					
Y 450 SS=E	449.231(1) First Aid a	and CPR		Y 450			
	NAC 449.231 1. Within 30 days after administrator or caregoresidential facility is enthe facility, the administrator must be trained cardiopulmonary advanced certificate in	giver of a employed at istrator or ined in first aid resuscitation. The					

AND DIAM OF CODDECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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Y 450	Continued From page	5		Y 450			
	adult cardiopulmonary issued by the America equivalent certification accepted as proof of t	an Red Cross or an n will be					
	Based on record revie did not ensure that 1		ity d				
Y 621 SS=E	449.2702(4)(b) Admis	ssion Policy		Y 621			
	and 449.2754, a resid	e provided in NAC 449 lential facility shall not ain in the facility any pe					
	Based on record revie interview from 10/1/10 facility failed to ensure restrained with the us (Resident #1 was una	through 10/11/10, the 1 of 3 residents were	not				

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		NVS4677AGC				10/1	1/2010
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Y 621	Continued From page	e 6		Y 621			
	Severity: 2 Scope: 2						
Y 878 SS=E	449.2742(6)(a)(1) Me	dication / Change orde	r	Y 878			
	the physician. If a ph the amount or times r administered to a res	tion prescribed by a ministered as prescribe ysician orders a chang nedication is to be ident: ponsible for assisting ir medication shall:	e in				
	Based on record revir 10/1/10, the facility faresidents received mon (Resident #2: Gabapa 3 times a day - medication to the resident by the evidence it was discomphysician; Resident # at bedtime - medication (PRN) medication for was not receiving the and there was no evidence the resident's phand Haloperidol were	illed to ensure that 2 of edications as prescribe entin 100mg, by mouth cation was not being give caregiver and there was intinued by the resident at Trazadone 100mg to was listed on the record as an "as-need depression. The residence of an order channysician. Morphine Sulfatentian in the second and the record as an apprescribed and the second and t	4 d. tab ven as no 's ablet ed" ent oed ge ate				

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	NV 0 10-7-1 0 0			A. BUILDING B. WING		1011		
		NVS4677AGC	070557 400	2500 0171/ 074	ATE 710 0005	10/1	1/2010	
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Y 878	Continued From page	2 7		Y 878				
	resident the medication	ons on a daily basis).						
	Severity: 2 Scope: 2	2						
Y 920 SS=F	449.2748(1) Medication	on Storage		Y 920				
	NAC 449.2748 1. Medication, including over-the-counter medications are at hat is cool and of caregivers employed shall ensure that any medical or diagnostic may be misused or agresident or any other person is protected. Mexternal use only must locked area separate medications. A reside of administering medication in his room medication is kept in a container for which the been provided a key.	I in a locked dry. The by the facility medication or equipment that opropriated by a unauthorized Medication for st be kept in a from other int who is capable cation to himself hay keep his in if the a locked	ny					
	Based on observation failed to ensure the armedications for 3 of 3	of met as evidenced by: n on 10/1/10, the facility rea used for storing residents remained loo by the caregiver (Resident	cked					

Bureau of Health Care Quality and Compliance

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Y 920	Continued From page	8		Y 920			
	Severity: 2 Scope:						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.